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ABSTRACT

This paper raises the question, "Do rehabilitation counselors know that handicapped clients have families?" Based on the contention that work with families is an important component in rehabilitation and that efforts must be made to include families of the handicapped in rehabilitation planning and process, the author reviews findings that relate to family influences on the disabled; explores model programs that include work with families; examines rehabilitation counselors' and educators' perceptions of the family's role in rehabilitation; and offers guidelines that may serve to stimulate the inclusion of the family in the rehabilitation process. (Author/KRP)

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PERSPECTIVES ON WORK WITH FAMILIES IN REHABILITATION

(or. . .Do Rehabilitation Counselors Know That Clients Have Families?)

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Studies show that family influences have direct bearing on the attitudes and behavior of handicapped persons. They also suggest that they may be importantly related to the outcome of rehabilitation. Little attention, however, is paid to this fact by rehabilitation counselors and/or rehabilitation counselor educators. One might well ask, do counselors know that patients have families? Writings and pronouncements of some leaders in the field suggest the need to view the handicapped person within the larger systems which surround him and certain rehabilitation programs do include work with families. These manifestations are rare and do not signify that the field as a whole sees need to enlarge the scope of practise. This is cause for alarm when one considers the vast amounts of money that are currently expended for rehabilitation in both public and private programs. Certainly there is need to insure that service recipients are well served. The day is long past when intent to serve can justify expenditures for programs which may not in fact accomplish worthy goals. Criteria for success such as the sixty day on the job standard cannot be accepted as adequate nor is there excuse for the field continuing to ignore findings that could contribute to strengthening practice.

It is the writer's contention that work with families is an important component in rehabilitation, that it is significantly related to outcome, and that efforts must be made to include families of the handicapped in rehabilitation planning and process. The paper will:

1. Review findings that relate to family influences on the disabled.
2. Explore programs that include work with families which might serve as models for others.
3. Examine the extent to which the family is perceived by rehabilitation counselors and educators as a factor in the rehabilitation process.
4. Offer guidelines that may serve to stimulate the inclusion of the family in the rehabilitation practice.

Let us first examine outcome studies to determine variables related to success. Limited studies are available and the validity of these may be open to question. Certainly the range of inquiry has been narrow, particularly as related to social-cultural and family variables. Weisbroth, Esibill and Zuger (1971), for example, studying 62 hemiplegics who had received extensive counseling at the Institute for Rehabilitation Medicine in New York, examined physical status, demographic data, cognition, and vocational program but included no variables related to motivation or family influences.[1] Scholl, Baumann and Crissey (1969) deplored that earlier follow-up studies left the relationship of multiple variables largely unexplored, yet proceeded to mount a study of the vocational success of the visually handicapped which included only one factor related to family influence: socio-economic status of the rehabilitant's family of origin, a variable found to be of no significance.[2]

Yet one does find studies which show that persons living in a family unit, whether that of origin or procreation, fare better in vocational success than unattached persons. Neff (1959) studied the employment status of 217 former clients of the Jewish Vocational Service in Chicago one year after completing program.[3] While data did not lend itself to statistical handling, he found success in employment associated with positive family attitudes toward the client and active family support. Age, intelligence, disability, and even prior employment experiences were unrelated. Clients, rated high on likely employability at the time program was completed and known to have high family support, were employed in greater numbers a year later while even those with lower predicted employability, but with high family interest, did better in gaining employment than those without family support. McPhee and Magelby (1958) in a study of a sample of 288 clients of the Montana Bureau of Vocational Rehabilitation 4-9 years after termination of program found significant differences between the substantially employed, the insubstantially employed, and the minimally employed in several areas: education, motivation, age, stable marriage

and family relationships.[4] At a 5% level of confidence, definitive differences existed between each of the groups in nine specific areas. For example, more of the substantially employed were married, had children, lived with and supported their families, participated in social activities with family members, had greater feelings of accomplishment related to family, attended church, and reported no family problems associated with their rehabilitation. Somewhat similar findings linking marital status and support of dependents with success in employment was evident in the 1964 follow-up study of 163 discharged tuberculosis patients treated at Cook County Suburban Hospital in Chicago.[5] Inversely, Olshansky, examining the characteristics of a group of physically disabled persons who could not secure employment subsequent to training at the Community Workshop in Boston from 1969-1973, found a heavy incidence of separated divorced, and widowed persons.[6] Wardlow and Sandovsky (1969) studying drop-outs from program found that persons attributed discontinuance to homesickness, family problems and other factors associated with dependency.[7]

Other studies of interest include Neuhaus' findings (1968) of behavioral characteristics of 206 rehabilitated mental patients,[8] Jarvik, Salzberger, and Falck's study of deaf persons who were outstanding successes (reported in Beatrice Cobb's Special Problems in Rehabilitation, 1974),[7] and the famous 1963 Simmons work on discharged mental patients.[9] Still others are included in the bibliography at the end of this paper.

Galloway and Goldstein report a somewhat different study (1971) in which an attempt was made to examine whether family therapy could influence the personal development and vocational performance of clients while undergoing rehab program.[10] Group therapy was offered to families of a group of 40 clients in a program associated with the Rehabilitation Department at Delgado Junior College in Florida. Families of a matched control group of clients received no therapy. Rehabilitation variables examined included such client factors as work organization, initiative,

perseverance, quantity of work produced meaningfulness of vocational objectives, and work adjustment. Client ratings were done at the onset of work with families and 16 weeks later; overall progress was assessed at the end of a year. While there were problems associated with program discontinuance by some parents and the differing approaches of the three therapists who ran the therapy sessions, the findings bear note. The group of clients whose parents were in therapy showed demonstrable changes in 10 out of 12 ratings as contrasted with 6 negative and 6 positive ratings for the control group. Client adjustment at the end of a year was compared for the two groups. More experimental group clients were in advanced school and training programs, making better grades and reporting greater satisfactions. They reported increased understanding by their parents, better satisfactions at home and felt that family attitudes were critical for their progress. Those on the job experienced fewer job changes. More control group clients were on the job with higher ratings by employers on work traits and vocational objectives. While this fact might raise question, the researchers attributed it to good counseling, i.e., clients with better potential were encouraged to seek further schooling or training rather than seek early placement. Although base line data on family attitudes toward clients was not established, scores of family members' understanding of clients were higher in the treated group of parents than in the untreated.

From the above studies one is led to conclude that families are contributory to client rehabilitation and that they do indeed positively support or adversely affect the process. That the Regional Rehabilitation Research Institutes have not chosen to conduct research related to outcome variables and/or family support factors is surprising, to say the least!

Data presented thus far tends to support the positive influence of the family on the disabled person undergoing rehabilitation. There can be a contrary effect as well. Klausner (1969) in intensive interviewing with a small group of families

with a disabled member, noted that the rehabilitation of several of his interviewees was retarded by the fact that their role as disabled persons had high value for their families who had in essence built their lives around their care and protection.[11] In such cases, the family tended to view the prospect of independence for a disabled member with less than enthusiasm. Klausner believes that it is not the individual who is disabled but the family. Consequently, the family becomes the logical unit of intervention. Rosenstock and Kutner (1967) point to the entry of a family member into rehabilitation as a family crisis affecting role complimentarity which is the basis of family stability.[12] When previously set family roles do not shift in accordance with the new role and expectations of the person entering into rehabilitation, there will be conflict and lack of support for his new behavior. Fordyce, a contributor to Neff's Rehabilitation Psychology (1971), speaks to re-enforcers in the home which sustain non-work behavior and the necessity to work with the family to shift contingencies that reward behavior not conducive to change.[13] Witness the inherent conflict between the reinforcements of the parent who resists his retarded son's learning to use public transportation and those of the travel trainer working to encourage travel self-sufficiency.

Lairy and Harrison, studying the effect of parental attitudes on congenitally blind children, noted the slow overall development of children whose mothers were unable to overcome their depression and alter their over-protectiveness.[14] Citing a matched study of blind adults at the New England Rehabilitation For Work Center (1962), Krause reported the greater vocational success of clients who did not live at home during the period of their training.[15] Non-dependent relationships of the new milieu were seen as more supportive to new behaviors than those of the old environment. Yet, these individuals would return home to be subjected once more to family attitudes. Whether family behaviors support change and progress, maintain status quo, or contribute to regression, they must be reckoned with. Freeman's

monumental work with discharged mental patients showed that the predictions and expectations of family members determine the behavior that subsequently occurs.[7] If successful behavior is predicted, it is more likely to occur. If previously regressed behavior is anticipated, the patient tends to live out this script. One should certainly not fail to recognize the value of family identification and participation in a process as significant for the disabled persons as rehabilitation Beppler (1974) in a follow-up of 34 disabled homemakers, trained at the Harmarville Rehab Center, learned that the development of organizational and managerial skill while critical for homemakers success had to be reinforced by family participation for success.[16] That family factors are related to outcome positively or negatively in as widely diverse groups of disabilities as are cited above should be testimony to the need to work actively with familes to reinforce positive influences, neutralize noxious forces, and foster new behaviors.

Rusalem speaks to "tying families more closely into the rehabilitation process as a timely approach which recognizes that successful rehabilitation rarely begins, functions, and terminates without active participation by the family."[17] In his opinion, agencies are increasingly taking families into such activities as individual and family counseling, family oriented programs, rehabilitation planning, and post care arrangements. The writer's response to this is that some are doing so, most are not, with the public vocational rehabilitation services the worst offender of all.

Let us now look at some of the programs that might serve as models. Rehabilitation programs dealing with children have the best record. Project Self Help in Peoria (1975) serving a group of multiply handicapped children from 3 to 8 in the public school program includes family counseling as an integral part of program.[18] Beck, in a recent manual, established guidelines for short term group treatment of parents of handicapped children.[19] Philage, Kuna, and Becerril mounted extensive work with families of children with learning disabilities. Parents and children

groups operated separately and in joint sessions accomplishing results not obtained by previous methods.[20] Rehabilitation programs for the visually handicapped child were early comers in work with parents. The experience of the Boston Center for the Blind[21] and the Birth Defects Clinic of the Colorado Medical Center is a matter of record.[22] Connor and Muldoon believe that family counseling needs to be built into the rehabilitation of the blind of all ages.[23] The record for work with parents of agencies serving deaf children has also been commendable. Examples are the Children's Diagnostic Center in Vancouver, British Columbia,[24] reported in 1975 and the Langley Porter Project in San Francisco.[25] Parents work side by side with children and teachers in the Bill Wilkerson Speech and Hearing Center in Nashville.[26] Work with families of the young adult deaf in a comprehensive rehabilitation program was found to be essential for success in altering the behavior of this undisciplined and unstable group. Aggressive work with parents was said to help them gain a perspective on their deaf young people and to define the role that they would need to play in the rehabilitation process. Staff of the St. Louis Jewish Employment and Vocational Center were firmly committed to work with this parent group although their children were adults.[27] Bennington in an unusual program utilizing Satir-Gestalt techniques helped families with a deaf member practice communication as a group by non-verbal methods, working to firming up family relationships that had been at best tenouous.

Experiments in work with families of other disability groups are beginning to find their way into the literature. Nau's work with the total family unit in the Arizona Job College Family Rehabilitation Project is well known for its combination of counseling, education for living skills, and vocational skills development.[28] Other programs have made similar approaches to the socially disadvantaged family, including Indian families. Erba writes of sessions with the family as an adjunct to psychotherapy with persons with renal disease undergoing dialysis.[29] To be

noted also are Delgado College Group Therapy Research Project mentioned earlier, Bellis and Sklar's orientation groups session for parents of retarded adolescents in a workshop program,[30] the Pittsburgh Cleft Palate Center's training and use of parents of cleft palate children for work with other parents (Irwin and McWilliams),[31] and group treatment of families of the burn injured (Abrahamson).[32] Evaluation of this last project showed that groups had provided a valuable means to help family members understand what patients go through, to become clear about program procedures, and to learn how to offer the disabled person necessary support. Families of stroke patients seen in admission conferences at a Veterans Hospital (Oradel and Waite),[33] in evaluating these later, pointed to their value in helping them voice concerns that could not be openly expressed, to gain necessary information, and to begin early planning for their family members. That nurses were less enthusiastic than others about the conferences shows that innovations are not always greeted with enthusiasm. No doubt families were emboldened to make requests and demands that were their right but which may have complicated the work of nursing staff.

Looking at the authors of the previously cited references, one notes that the innovators and contributors have generally been members of other disciplines than rehabilitation; psychologists, sociologists, educators, and social workers. These people appear to be more curious, more ready to try new approaches, and certainly more inclined to write about them than rehabilitation counselors. The latter contribute little to the literature, or in fact to experimentation with new approaches, unless they are involved in programs that straddle the fields of rehabilitation and social work or rehabilitation and education. Periodicals in the field, abstracts of research in the field, other indexes, and standard references in rehabilitation education (including the training manual, An Introduction to the Vocational Rehabilitation Process which has been the Bible of vocational

rehabilitation counseling) turn up few references which suggest that rehabilitation counselors work with, or consider working with, families within their purview.

J.E. Muthard studies a large sample of 378 rehabilitation counselors employed in state rehabilitation programs and rehabilitation facilities to ascertain perception of functions and roles.[34] Counselors saw their primary functions as affective counseling, vocational counseling, case supervision, and placement. In the same study, leaders in the field, not in direct practice, wanted more emphasis on work adjustment counseling as compared to therapeutic work with clients. Rehabilitation counselor educators saw need for more affective and interpersonal counseling. None made mention of counseling or consulting with families. Proof, indeed, that families do not exist for rehabilitation counselors.

Granted that practice generally lags behind education in most disciplines, we might expect that rehabilitation educators would be on the leading edge of change. Not so if one attributes importance to studies like the above; or, if one reviews the curriculum of representative graduate programs, task force reports on curriculum design, or the proceedings of conferences on new directions in practice. No where is there indication that courses in the standard programs give students awareness of the larger systems within which the rehabilitant moves, including the family.

Christopherson, a respected writer in the rehabilitation field, points to the fact that rehabilitation reverses the law of the survival of the fittest and poses a new and higher moral law. In doing so it must then be aware that restoration of function and work capacity is but one part of its responsibility; its mission being met only as it ceases to concentrate on the individual and becomes concerned for interpersonal and family competence. Robert Scott deplores the fact that rehabilitation relationships are conceptualized in individualistic and psychological terms.

> Focus is on the individual. The problem of disability is thought to be like a trait, something inherent in an individual. The process is not thought of as part of a complex social system

> involving family, friends, and community. When rehabilitation fails, explanations are ordinarily psychological, such as the disabled person not being ready for service or resisting or failing to accept his handicap.....Rehabilitation is a sociological process.[35]

Others on the vanguard of progress such as Sussman, Haug, and Joynes call for new directions in training, suggesting a many-faceted counselor role which would require that the counselor "bring discrete systems together, linking and creating new sub-systems."[36] Vernon McCoy, writing of his experience in rehabilitation of the deaf, concludes that parental involvement has been a tremendous breakthrough in the field, a primary factor in improving the chances of the deaf.[37] Trela and O'Toole implore the counselor to get out of his office and meet clients in their natural settings. Olshansky articulates the dilemma of the counselor:

> The counselor finds it difficult to understand that he is involved in many conflicting and interconnected systems which may hinder the counselor and client from functioning effectively. Unless attention and thought are given to the idea of systems and ways of coping with various systems at different points in time, the counselor will continue to experience frustration."

Usdane and Ayers at the 3rd Annual Conference of the International Association of Rehabilitation Facilities recognized that the "field has been deeply conditioned to rehabilitation as an individual process and indicated that the time has come for new approaches."[38]

The present counseling model, spawned from a mixed brew of psychology, medical model, and vocational guidance and training has fostered a super-ordinate, sub-ordinate relationship which binds client and counselor together in a highly intense personal relationship. Another model makes the counselor a broker or a merchandizer of services. Time for a new model based on an ecological perspective which views the individual within the context of family relationships and a larger interactional networks. In such a model, clients' interactional system is the target and interventions extend beyond the individual client to include significant

others. It also emphasizes a more egalitarian relationship with shared responsibility for decision making and control of the rehabilitation process.

What then are the roadblocks to change? One can indict the mossback conservatism of the profession, the infatuation of many counselors with psychotherapy, bureaucratic pressures and the fact, as one leader in the field admits, that practice is under the contingencies of other factors than ultimate effectiveness. But, it is less important to rail at the obstacles than to attack them in whatever form they occur whether the sanctity of established authority, peer consensus, professional inertia, the heavy weight of tradition, or the use of artificial outcome criteria like closures as indicators of success.

In conclusion, then, one can say that:

1. The rehabilitation field in general has shown little interest in examining whether, as a result of rehabilitation services, persons are in fact possessed of better work capacity, more finely honed living skills, greater personal satisfaction, and enhanced opportunity for actualization of human potential. More attention must be paid to identifying variables related to outcome in its broader sense as defined above.

2. A missing component of service has been work with families. The individual patient is still perceived as a free standing entity rather than a person in a larger interacting social system. Practice remains the captive of an outmoded model which, emphasizing individual counseling, puts the family out of bounds.

3. Practitioners, especially in the public vocational rehabilitation programs, seem reasonably content with the status quo. Nor do rehabilitation counselor educators appears to be disquieted with things as they are. If so, they are in no haste to make curriculum changes.

4. The rehab field will achieve creditable professional status alongside other disciplines only as it faces up to the circumscribed nature of its present practice.

5. Models for interventions with families exist in selected settings. These can be utilized in other settings once the field develops greater consciousness of need.

What is needed then appears to be a spell of consciousness raising, one aspect of which should compel attention to the family as a component in the intervention system. Once awareness exists of how this could enrich practice, a number of strategies are available to operationalize the concept. These include contact with family members of new clients at the onset of program for joint goal setting and program determination, orientation groups for families of new clients, patient and family progress reviews, ongoing family therapy when role adjustments of family members impede the process wherein the disabled person is struggling to assert himself, and other strategies. Family inputs into the rehabilitation are needed and can be included in many ways. Families themselves can be utilized to help other families and closer relationships can be established with community service agencies offering assistance to families. Techniques for family work can be easily learned once there is conviction that they are critical for improved practice. No better time than the present when funding sources increasingly demand accountability and consumers raise hue and cry about getting their just desserts. Time to affirm that clients do indeed have families!

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FOOTNOTES

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